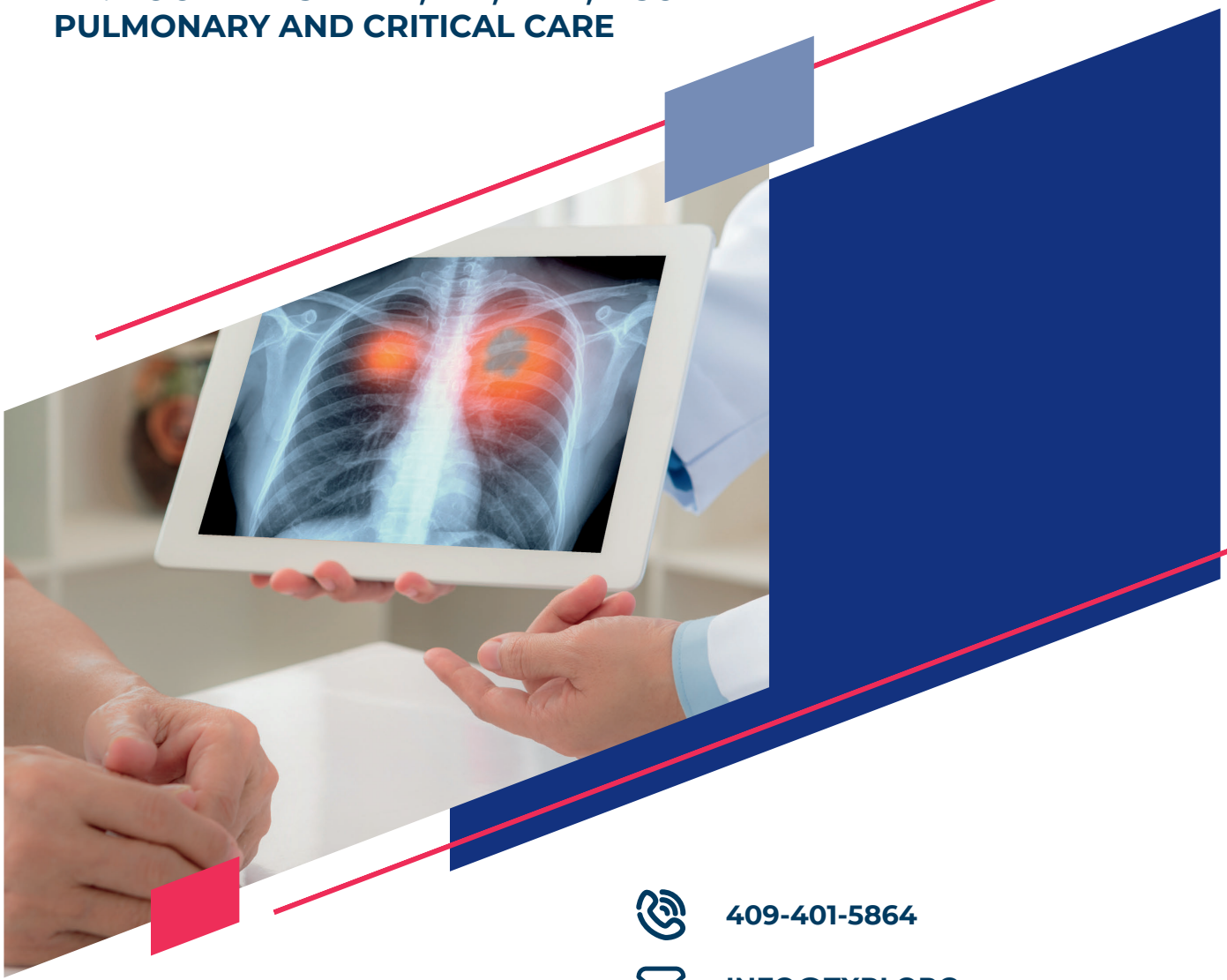
Welcome to
Texas Pulmonary Institute
Healing Breathlessness for Better Life

PATIENT RENEWAL

DR. ROOZBEH SHARIF, MD, MED, MSC
PULMONARY AND CRITICAL CARE



409-401-5864

INFO@TXPI.ORG

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WWW.TXPI.ORG

2023

Texas Pulmonary Institute
Healing Breathlessness for Better Life

Welcome to Texas Pulmonary Institute! We love our patients!

Please complete the renewal packet attached to ensure we have the most up-to-date information. We will ask you to perform this task annually.

Our mission is to heal breathlessness for a better life. We appreciate you choosing our clinic for your pulmonary needs.

When calling our office, always call (409) 401-5864.

When we prescribe a medication, or order labs or testing for you, please be patient with us.

There is a process we must go through with any order, but we try our best to get it sent immediately.

Certain tests we order must go through insurance authorization and for these orders it can take up to 10 days to be approved.

When getting labs drawn it takes 48- 72 hours for results to be sent to us.

Imaging (CT and chest x-rays) can take 2-3 days to get scheduled and 4-5 days to get results back from radiology center.

PET scans all require insurance authorization and will take about 14 days just to be scheduled.

Medications: We try our best to get your prescriptions sent over straight from your appointment, but some medications can take longer. If you do not hear from your pharmacy in 24 hours, please let us know.

We apologize in advance for all delays in all above.

We DO take your care, health, and safety VERY seriously.

If you must cancel or reschedule, please give our office the courtesy of 24 hours notice by calling (409)401-5864 before your scheduled appointment.

We look forward to serving you at Texas Pulmonary Institute.

Preferred Pharmacy _____

Location _____Phone (_____)_____

Any allergies to medications: □ Yes □ No □ Unknown

If so what Medication / Reaction _____

_____

_____

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS AND VITAMINS AND SUPPLEMENTS

Medication Name	Strength mg, mcg, etc.	How often 1 X day, 2 X day, etc.	Reason for taking (Heart, blood pressure, etc.)

Epworth Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these activities recently, try to work out how they would affect you. Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze	1= Slight chance of dozing
2 = Moderate chance of dozing	3 = High chance of dozing

Situation	Chance of Dozing			
	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (theatre, meeting, etc)				
As a passenger in a car for an hour without break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				
Total				

Stop-Bang Patient Questionnaire

Question		Yes	No
Snoring	Do you Snore Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?		
Tired	Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)?		
Observed	Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep ?		
Pressure	Do you have or are being treated for High Blood Pressure ?		
Body	Body Mass Index more than 35 kg/m^2?		
Age	Age older than 50?		
Neck	Large Neck size		
Gender	Are you male?		

OSA - Low Risk: Yes to 0 - 2 questions OSA - Intermediate Risk: Yes to 3 - 4 questions OSA - High Risk: Yes to 5 - 8 questions or Yes to 2 or more of 4 STOP questions + male gender or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m^2 or Yes to 2 or more of 4 STOP questions + neck circumference 16 inches / 40cm

Total

Due to the Health Information Portability and Accounting Act (HIPAA) of 1996, the following information must be filled out by each patient annually*.

Please initial each statement at your discretion

_____ I authorize Texas Pulmonary Institute to release and receive my medical or insurance information as necessary to process my medical claims and coordination or manage my healthcare.

_____ In the event of a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give Texas Pulmonary Institute and its physician, providers, or employees my permission to discuss freely my condition, treatment, diagnosis, or pregnancy with that person.

Patient Contact Numbers:

Home: _____ Mobile: _____

Work: _____ Other: _____

May we leave a message at one or more of the numbers listed above regarding appointments and/or test or lab results?

☐ Yes ☐ No

☐ Home ☐Mobile ☐Work ☐Other ☐All of the above

With whom may we discuss or release information about your care, treatment, diagnosis or pregnancy?

Name:_____Relationship:_____Number:_____

Name:_____Relationship:_____Number:_____

Name:_____Relationship:_____Number:_____

Patient Signature: _____ Date: _____

Personal Representative/Witness Name: _____

Personal Representative/Witness Signature:_____

Relationship: _____ Date: _____

PRIVACY NOTICE AND CONSENT TO TREATMENT

Please read and initial each statement to confirm understanding of the authorizations/consent listed below.

_____ I voluntarily consent to the rendering of medical care, treatment, and diagnosis, including such diagnostic, therapeutic or medical procedures to be performed by my attending physician, his or her designee, or assistants as is necessary in his or her judgment.

_____ I understand that treatment may involve risk. I understand that emergency or major procedures will not be performed on me until I have had the opportunity to discuss such procedures and the risks associated to my satisfaction with my physician or other health care provider and have consented to such procedure. Further, I understand that medical, nursing and other health care personnel may participate in my care and treatment as part of procedure.

_____ I understand that Texas Pulmonary Institute will keep records that contain my medical, personal, and other information related to my diagnosis, care, and treatment in electronic and paper format.

_____ I hereby assign to Texas Pulmonary Institute the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to Texas Pulmonary Institute. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

_____ I understand that Texas Pulmonary Institute may release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary for claim processing

____ I authorize Texas Pulmonary Institute to request my medical information including complete medical records, test results, and insurance information from medical professionals that I have received treatment including my referring physician/practitioner, primary care physician, specialists, and/or medical care institutions that may be necessary to improve coordination of care

____ I authorize Texas Pulmonary Institute to release my medical information including complete medical records, test results, and insurance information to medical professionals including my referring physician/practitioner, primary care physician, and/or medical care institutions that I may be referred to for treatment to improve coordination of care

_____ I understand that insurance may not pay the full amount of my charges and I acknowledge that I am financially responsible and agree to pay my bill for non-covered services, as well as any deductibles, copays, or co-insurance. If I am uninsured, I agree to assume full financial responsibility for payment of all charges.

My signature below constitutes my acknowledgement that I have read and understood the above information, and that I agree to this consent of treatment, payment and medical release as described herein.

Patient Signature_____Date_____

Personal Representative/Witness Name: _____

Personal Representative/Witness Signature: _____

Relationship: _____ Date: _____

Texas Pulmonary Institute

No Show, Late and Cancellation Policy

Effective 12/01/2022

"No Show" shall mean any patient who *fails to arrive* for a scheduled appointment. **"Same Day Cancellation"** shall mean any patient who cancels an appointment *less than 24 hours* before their scheduled appointment. **"Late Arrival"** shall mean any patient who arrives at the clinic *15 minutes after* the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Our goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required **to call or leave a message at least 24 hours** before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

Failure to provide 24 hours' notice will result in a $50 charge being billed to the patient account.

Established patients

Appointment must be cancelled at least 24 hours prior to the scheduled appointment time. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available. If appointments are not yet available for their provider, a reminder will be placed for the patient to call to make a future appointment once the schedule opens. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from Texas Pulmonary Institute. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with the TPI policy.

New patients

Appointment must be cancelled at least 24 hours prior to scheduled appointment time. In the event of a no-show, Texas Pulmonary Institute may require a new referral sent from the referring physician. In the event a patient arrives late as defined by "late arrival" to their appointment, the Texas Pulmonary Institute reserves the right to request a new referral sent from the referring physician. In the event of three (3) documented "same-day cancellations," the patient may be subject to dismissal from Texas Pulmonary Institute. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with the TPI policy.

Please read and initial statement(s) below to confirm understanding of fees you may be responsible for while receiving care here at Texas Pulmonary Institute.

____ I read and understand that cancellation less than 24 hours before my appointment, late arrival, or a no show is subject to a fee of $50 being charged to the patient or responsible party*.

Patient Documentation and Records Requests

We understand that many circumstances and other providers may ask for documentation from our office such as disability paperwork, records requests, unemployment or workman's compensation documents and the related. We will be happy to accommodate these requests, however, we require **a 48–72-hour processing time for completion and a fee of $30 that will be charged and due upon pickup of documents requested.**

While we will always do our best to complete these quickly, please do not expect same day service, and make any adjustments accordingly.

____ I understand that outside forms provided to the medical professionals at Texas Pulmonary Institute to complete including work release and disability forms require a 48–72-hour processing time. A Fee of $30 may be collected once forms are completed, before completed forms are released.

Returned Check Fees

Texas Pulmonary Institute reserves the right to charge a $30 fee on any returned personal checks. Once we receive a returned check, we will no longer accept personal checks as a form of payment on your account.

____ I understand that a returned personal check is associated with a fee of $30 and if a personal check is returned for non-payment, I will be unable to secure payment with TPI using personal checks in the future.

I,_____, authorize *Texas Pulmonary Institute* to charge my patient account for the fee associated with items listed above. I understand that I will be responsible for paying the balance of these charges prior to any scheduled visits.

Patient Signature: _____Date: _____

*In compliance with applicable law and the Texas Labor Code, there are NO fees charged for late arrival, no show or missed appointments for Medicaid and Workman's Compensation patients.